

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935

FAX #: (608) 261-7083
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1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@dps.wi.gov
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DIETITIANS AFFILIATED CREDENTIALING BOARD

APPLICATION FOR CERTIFICATION TO PRACTICE AS A DIETITIAN

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

☐

Your name and address are available to the public.

Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14)

PLEASE TYPE OR PRINT IN INK

Last Name	First Name	MI	Former / Maiden Name(s)
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Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth _____ month day year	Daytime Telephone Number () _____ - _____
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Ethnic/gender status information is optional. Sex: ☐ M ☐ F Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? ____ Yes ____ No (please indicate)
If yes, provide your Wisconsin license/credential number. _____

School Name: _____
(Dietitian degree for credentialing)

School Address: _____
(City) (State)

Date Diploma Granted: _____
month/day/year

Degree: (Circle one) BS MS Dr Other Specialty: _____

BOARD OFFICE USE ONLY

Temporary Permit Requested: ____ Yes ____ No

APPLICATION FEES Please check applicable blank: (Make check payable to Department of Safety and Professional Services and attach to application).

EXAM CANDIDATE:

\$ 75.00 Total Fee Attached

TEMPORARY CERTIFICATE ISSUED PRIOR TO PERMANENT CERTIFICATION (Only for candidates applying by examination)

\$ 10.00 Is required in addition to the above fee (non-refundable)

RECIPROCAL CANDIDATES: (Candidates who hold or held a credential in another state and have taken the ADA* examination)

\$ 75.00 Reciprocal Fee

RECIPROCAL CANDIDATES: (Candidates who have taken a state board examination other than ADA* examination)

\$ 75.00 Reciprocal Fee

*American Dietetic Association

#2113 (Rev. 4/13)
Ch. 457, Stats.

For Receipting Use Only

Wisconsin Department of Safety and Professional Services

PLEASE REVIEW SECTIONS 1-4. CHECK THE SECTION UNDER WHICH YOU ARE SEEKING A CREDENTIAL. Under each section is a list of documents required for the credential. **Your application will not be considered complete until all of these documents have been received in the board office.** For your convenience we have added a check list.

SECTION 1

☐ **PERMANENT CERTIFICATION BY EXAMINATION.**

- ☐ Completed application (Form #2113)
- ☐ Fee(s) attached to this application (Form #2113)
- ☐ Certificate of Professional Education (Form #2111)
- ☐ Proof of passage of the American Dietetic Association (ADA) examination, or "Verification of Registration" (Form #2115)
- ☐ Practice of Dietetics (Form #2128)
- ☐ Social Security Number (Page 6 of 6 Form #2113)

SECTION 2

☐ **PERMANENT CERTIFICATION FOR RECIPROCAL CANDIDATES (who held or holds a credential in another state and has taken the American Dietetic Association (ADA) Examination).**

- ☐ Completed application (Form #2113)
- ☐ Fee(s) attached to this application (Form #2113)
- ☐ Certificate of Professional Education (Form #2111)
- ☐ Proof of passage of the American Dietetic Association (ADA) examination, or "Verification of Registration" (Form #2115)
- ☐ Practice of Dietetics (Form #2128)
- ☐ Social Security Number (Page 6 of 6 Form #2113)
- ☐ A letter of verification of licensure or certification from another state or U.S. Territory submitted directly from that state board.

SECTION 3

☐ **PERMANENT CERTIFICATION FOR RECIPROCAL CANDIDATES (who have taken a state board examination other than the American Dietetic Association (ADA)).**

- ☐ Completed application (Form #2113)
- ☐ Fee(s) attached to this application (Form #2113)
- ☐ A letter of verification of licensure or certification from another state or U.S. Territory submitted directly from that state board.
- ☐ A copy of the state's rules and regulations pertaining to the practice of dietetics.
- ☐ Social Security Number (Page 6 of 6 Form #2113)
- ☐ Certificate of Professional Education (Form #2111)
- ☐ Practice of Dietetics (Form #2128)

SECTION 4

☐ **TEMPORARY CERTIFICATE issued prior to permanent certification. (Only for candidates applying by examination.)**

- ☐ Completed application (Form #2113)
- ☐ \$85.00 fee attached to this application (Form #2113)
- ☐ Certificate of Professional Education (Form #2111)
- ☐ Practice of Dietetics (Form #2128)
- ☐ Request for a Temporary Dietitian Certificate (Form #2112)
- ☐ Social Security Number (Page 6 of 6 Form #2113)

Wisconsin Department of Safety and Professional Services

IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT A CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.

PLEASE CHECK ONE FOR TEMPORARY CERTIFICATE:

_____ I plan to take the next ADA Registration Examination on _____ / _____ / _____
mo day yr

_____ I have taken and am awaiting the results of the ADA Registration Examination.

I AM CREDENTIALLED IN THE FOLLOWING STATES (UNLIMITED):

YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN CREDENTIALLED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN DIETITIANS AFFILIATED CREDENTIALING BOARD. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, CREDENTIAL NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR CERTIFICATION.

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary)

	<u>YES</u>	<u>NO</u>
1. Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/>	<input type="checkbox"/>
4. Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any felony or misdemeanor charges pending against you? If yes, submit Convictions and Pending Charges (Form #2252). Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been convicted of a misdemeanor or a felony? If yes, submit Convictions and Pending Charges (Form #2252). Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	<input type="checkbox"/>	<input type="checkbox"/>
8. Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	<input type="checkbox"/>	<input type="checkbox"/>
9. Have your privileges ever been limited or removed? If yes, give details on an attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	<input type="checkbox"/>	<input type="checkbox"/>

Wisconsin Department of Safety and Professional Services

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice as a dietitian" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned dietetic judgments and to learn and keep abreast of dietetic developments; and
2. The ability to communicate those judgments and dietetic information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform dietetic tasks such as examination and treatment procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

	<u>YES</u>	<u>NO</u>
12. Do you have a medical condition which in any way impairs or limits your ability to practice as a dietitian with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
13. Does your use of chemical substance(s) in any way impair or limit your ability to practice as a dietitian with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
14. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
15. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
17. Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/>	<input type="checkbox"/>
18. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>

Wisconsin Department of Safety and Professional Services

CERTIFICATION OF LEGAL STATUS.

I declare under penalty of law that I am (check one):

_____ a citizen or national of the United States, or

_____ a qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at <http://www.uscis.gov>.

ALL APPLICANTS MUST COMPLETE THIS SECTION

AFFIDAVIT OF APPLICANT

(Sign and date in the presence of a notary)

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.

Signature of Applicant

Date

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20____, by _____
(Applicant name)

Signature of Notary Public

S E A L

Date Commission Expires

Wisconsin Department of Safety and Professional Services

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.¹ A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

First Name	Middle Initial	Last Name
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Profession

Date of Birth

month

day

year

			-			-				
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Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Children and Families for purposes of administering the child and spousal support program,² to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,³ and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.⁴

EMAIL ADDRESS:

Do you have an email address?

☐ Yes

☐ **No**

If yes, this field is required to receive your application status electronically. Your email address must be clearly legible with the correct case sensitive information.

EMAIL ADDRESS: Submit your email address in the spaces provided below or attach a printer copy.

[illegible]

If no, your checklist will be sent by first class mail.

¹ Section 440.03 (11m), Wis. Stats.

² Sections 49.22, and 440.13, Wis. Stats.

³ Section 440.12, Wis. Stats.

⁴ Health Insurance Portability and Accountability Act (HIPAA) of 1996